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Northern Virginia Long-Term Care UPDATE

Information and Issues from Northern Virginia Long-Term Care Ombudsman Program

Advocacy for the Elderly: Access to Pain and Symptom Management

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Pain, among other things, can be profoundly disabling. To put it bluntly, "pain kills." Pain reduces mobility, which in the elderly increases mortality. Pain diminishes the immune system, putting the elderly more at risk for infectious disease. Pain stresses the heart, increases blood pressure and reduces insulin response. It causes depression, anxiety and suicidal thoughts. Untreated pain is known to "rewire" the neurological pathways so that the pain can remain, grow and even spread after the underlying original cause of pain is cured. Failure to understand this neurological change often causes physicians to belittle or disbelieve the continuing pain.

Nursing Home Residents Have Untreated Pain

Many elderly residents enter nursing homes in pain and remain in pain. As reported in *Journal of the American Medical Association*, 40% of nursing home residents who had pain on their first assessment experienced moderate to excruciating pain daily 60 to 180 days later. (These data were collected only from persons who were not demented.) Many additional studies demonstrate the frequency of untreated and undertreated pain in nursing homes.

Risk Factors for Untreated Pain

- Non-cancer diagnosis: We know that "cancer hurts." Much less attention is paid to the severe pain of chronic illnesses. These illnesses are far more common in nursing homes than cancer and the pain is far less well assessed and treated than cancer.
- Age: An extensive study of nursing home patients showed that nurses consistently underestimated pain levels in residents–choosing to treat grimacing, etc, as signs of psychological distress rather than physical pain. Validated tools for assessing pain, even in the cognitively impaired, exist and should be used consistently.
- Women: American culture expects women to be more able to handle pain than men—and their complaints are more often deemed "psychosomatic". Epidemiologically, more women than men suffer from some of the more mysterious painful diseases such as migraine and fibromyalgia.
- Dementia: A comparative study of demented and not demented elderly patients with broken hips or pneumonia showed that the demented received less than half the pain medications given to those who were cognitively intact. When demented people have conditions that are painful, the pain should be treated even though they cannot articulate well what is happening to them.

Common Myths about Pain in the Elderly

- *"The elderly feel less pain"*. Clinical studies show that the elderly may be more

sensitive to chronic pain than younger persons, not less. Moreover, the elderly have had a long time to accumulate painful diseases and conditions and are more at risk for others—such as decubitus ulcers—in the nursing home.

- *"The resident will become an addict."* - Addiction is extremely rare to non-existent for elderly persons receiving opioids. Addiction among all patients taking opioids as prescribed is less than 1%.
- *"I'll lose my license" or " I'll go to jail."* - State intractable pain acts and/or medical board guidelines permit and encourage pain management using opioids for chronic intractable pain. State laws also protect "comfort care" pursuant to advance directives. As long as a physician documents his reasons for prescribing strong pain medications such as opioids, and follows established clinical practice guideline, he has no reason to fear sanctions.
- *"Pain management is a form of chemical sedation/restraint."* - Sedation can be a side effect of opioids, but is usually manageable if a physician is willing to pay attention. For example, gerontologists who manage pain can use Ritalin or some other stimulant as a combination anti-depressant and sedation-overcoming medication. Virtually no side effects are reported.
- *"The elderly are already over medicated."* – This may be true but is no reason to exclude one category of medication. Additionally, failure to manage pain can exacerbate dementia and cognitive dysfunction.
- *"Opioids are too dangerous to use in the elderly."* - Any medication can be dangerous, including aspirin, ibuprofen and other over the counter pain medications. The American Geriatric Society has issued guidelines that support the use of opioids to treat geriatric pain that cannot be managed with lesser medications. Every physician accredited to a nursing home should be familiar with these guidelines, which include references to clinical studies and data.

Nursing homes and physicians have a legal and ethical obligation to treat residents' pain.

The standard of care for patients of all ages is now to treat pain. The obligation to do so now falls within the scope of physician and nursing home obligations. The facilities should understand that the standard of care has changed and that they are legally at risk if they fail to insist that pain be assessed and treated according to that standard. There are now a number of approaches to pain management failure:

1. Elder Abuse and Neglect: Virginia defines "abuse" as the willful infliction of physical pain or mental anguish. Neglect constitutes a failure to provide mental and physical health services so as to impair mental and physical health and well being. A California jury awarded the family of a deceased patient $1.5 million for a doctor's failure to treat the serious pain of a dying patient and several similar suits are pending in other states. The Virginia statute allows for the same cause of action against facilities and physicians.
2. Medical Malpractice: Nursing home physicians who fail to treat pain or nursing professionals who fail to carry out orders given are potentially liable for medical malpractice. This tort can be proven if medical care falls below the standard of care in the community. As more and more professional associations and state legislatures establish clinical guidelines and pain management expectations, the standard of care is becoming much easier to prove. Over the past decade a clear standard of

care relating to pain assessment and treatment has emerged.

- The Joint Commission on Accreditation of Health Care Organizations: JCAHO established standards several years ago for pain management and assessment in every accredited facility. These standards do not apply directly to the many nursing homes in the state that are not accredited. However, they are imported into the Medicare and Medicaid requirements that nursing homes provide for the highest possible functioning in residents.

Professional societies have also created standards and have them available on line.

- American Geriatric Society – Guidelines for Treatment of Chronic Pain in the Elderly
- American Medical Association (AMA)/EPEC – A detailed site that provides information for treating all phases of pain and other symptoms as well as resources for physicians and facilities to address psychological and social aspects of end of life.
- American Pain Society/American Academy of Pain Management—Guidelines for the use of opioids in chronic pain management, definitions that distinguish addiction and tolerance.
- AMA Ethical Standards 2.17: Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death.
- AMA House Resolution (2001): "AMA will work: (1) to promulgate clinical practice guidelines for pain control in long term care settings…and (2) to reduce regulatory barriers to adequate pain control… for long term care patients."

3. Infliction of emotional distress

   This tort does not require intent; it may be done negligently under some circumstances. No proof of physical injury is required for intentional infliction in most states. Where bodily harm is required, pain itself has been held sufficient to sustain an action, as have insomnia, stress, and other typical concomitants of pain. Substantial new medical writing treats chronic pain as having its own pathology that "rewires" nerve circuits so that, even if the original cause of pain is relieved, the patient may still experience pain.

4. Abandonment

When a physician neglects a patient's care there may be a claim of abandonment, which is a common law tort recognized in most states. It is a subset of malpractice, but has some different rules and need not, in all states, always be established by expert testimony.

The Message to All

One of the fundamental rights of a resident must be the right to serious and constant assessment of pain and attention to painful conditions. This is the same standard of care that applies to other medical conditions but is often neglected. Healthcare professionals need to be alert to the possibility of under treatment and be willing to address it in the facilities they oversee.

Mary Baluss is the general counsel of the National Foundation for the Treatment of Pain and Director of the Pain Law Initiative. She welcomes questions and requests for assistance at mbaluss@yahoo.com.

" PAIN IS A MORE TERRIBLE LORD THAN DEATH ITSELF"…
Albert Schweitzer

Communication Corner

Pain Management in Cognitively Impaired Long-term Care Residents

Wentz (2001) reports that many recent studies have shown that cognitively impaired patients are undertreated for pain. This is a common problem for residents of long-term care facilities. Assessment of pain in cognitively impaired older adults is complicated by changes in memory, language skills, and their ability to conceptualize pain. Wentz further asserts that due to these changes, clinicians sometimes prematurely conclude that a cognitively impaired patient cannot report pain or use a pain rating scale.

However, Feldt (2000a) suggests that the under-treatment of pain in cognitively impaired residents of long-term care facilities could be improved by using instruments that are easily understood and observation measures that detect pain. Therefore, the focus here will be on assessment methods, which utilize observation and nonverbal indicators of pain.

According to Feldt (2000a), observations of pain behavior should be made during movement or palpation of the suspected painful area when the resident is more likely to perceive pain and cry out. Evidence of pain, such as poor appetite, depressive symptoms, changes in sleep patterns, falling, refusal of care, and agitated behavior should be documented. Common signs displayed by people with dementia experiencing physical discomfort include: fidgeting, tense muscles, body bracing, increased calling out or repetitive verbalizations, noisy breathing, grimacing, moving extremely slowly, increase in pulse, blood pressure, and sweating.

Instruments to detect pain in nonverbal, cognitively impaired elders are being developed and tested. One assessment tool discussed here is the "Checklist of Nonverbal Pain Indicators" developed by Feldt (2000b). It is an observation tool designed to assess pain in cognitively impaired elders. The scale includes those behaviors most frequently cited: nonverbal vocalizations (defined as sighs, gasps, moans, groans, or cries); facial grimacing or wincing (defined as furrowed brow, narrowed eyes, clenched teeth, tightened lips, dropped jaw, or distorted expression); bracing (defined as clutching or holding onto furniture or equipment or the affected area during movement); restlessness (defined as constant or intermittent shifting of position, rocking, intermittent or constant hand motions); rubbing (defined as massaging the affected area); and vocal complaints. A score of 0 is recorded if the behavior is not observed and a score of 1 if the behavior is observed. Scores are recorded with movement and at rest.

For more information on pain management, please review the references cited.

References

Feldt, K. 2000a. "Improving Assessment and Treatment of Pain in Cognitively Impaired Nursing Home Residents". *Annals of Long-Term Care: Clinical Care and Aging*, 8(9), 36-42.

Feldt, K. 2000b. "The Checklist of Nonverbal Pain Indicators". *Pain Management Nursing*, 1(1),
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Wentz, J. 2001. "Assessing Pain in Cognitively Impaired Adults". http://www.findarticles.

The Communication Corner addresses information on dementia and dementia-related diseases. Please address comments to *ythom1@co.fairfax.va.us*

Assessment of the Management of Pain in Northern Virginia Nursing Facilities

Based on a request by the Fairfax Commission on Aging, the Northern Virginia Long-Term Care Ombudsman Program surveyed the 32 nursing facilities within Northern Virginia regarding their assessment and management of pain in residents. The results indicate the following:

- The three most common pain medications used are Percocet (25), Acetaminophen (23), and OxyContin (19).
- Twenty-eight of the facilities assess pain daily through a formal assessment tool and 29 incorporate pain management into resident's care plan.
- Sixteen facilities report that residents with chronic pain receive pain management primarily PRN, 26 report that resident receive long acting medications, and 22 report that they also use breakthrough medications if using long acting pain ones.
- Twenty-seven facilities have held inservice training on pain management.
- Twenty-nine facilities indicated that they would hold an inservice on pain management if a speaker was provided and 25 would attend if educational seminars were offered.
- Thirty facilities indicate that they have a contract with Hospice.
- Ten facilities indicated that they have a geriatrician available with credentials for chronic pain management.
- Twenty-two indicate that they have one or more physicians that are familiar with The American Geriatric Society's guidelines for the use of opioids for chronic pain in the elderly, while four are uncertain about this. Thirty facilities indicated that they would like a copy of this guideline, while 27 would be willing to recommend that their physician review this document.
- Four facilities indicated that they have physicians who have taken the American Medical Association Education for Physicians in End of Life Care (EPEC) course, while 19 facilities indicated that they are uncertain if the physicians have taken this course. Twenty-three indicated that they would be willing to recommend that the physicians take this course.

Overall the results indicate that facilities are assessing pain and would be interested in further education / training on pain assessment and management.

Guideline information:

Information on the American Geriatric Society's guidelines for the use of opioids for chronic pain in the elderly is available at www.americangeriatrics.org/products/chronic_pain.pdf

Information on the *American Medical Association Education for Physicians in End of Life Care* course can be obtained on line at End of Life Physician Education Resource Center (EPERC) at www.eperc.mcw.edu.

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This brochure is also available in alternative formats.

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We're so Grateful, We are Singing!

National Volunteer Appreciation Week is in April, so we want to join our voices to the chorus of praises for the wonderful Volunteer Ombudsmen in our program!

In the year 2001 fifty-five (55) ombudsmen contributed a total of **7,918 hours**, making a total of 3,284 visits to the residents of all 31 nursing homes in our region and 37 of the assisted living facilities!

We're singing songs of admiration for their commitment to and compassion for some of the frailest and most vulnerable people in our communities. These volunteers helped to provide on-site access to advocacy services to a *minimum* of **7,900 individuals** (not counting the significant turnover in bed occupancy).

Our volunteers did their best to work in a supportive, team approach with the management and staff of the facilities. The compliments we often hear about our volunteers from them are a wonderful testimony to this. Residents and their family members are equally quick to offer praise. The work of a Volunteer Ombudsman isn't easy; at times it can be downright hard. So, we want to say (sing?!) a big "THANK YOU!" to each one for a job well done!

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